IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 31, 2006

Tracy Farnsworth, Administrator
State Hospital South
PO Box 400
Blackfoot, ID 83221

Dear Mr. Farnsworth:

This is to advise you of the findings of the Fire Safety JCAHO Validation survey of State Hospital South which was done on June 26 and June 27, 2006.

Enclosed are Statement of Deficiencies/Plan of Correction forms, HCFA-2567s, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for these deficiencies. If you do choose to submit a plan of correction, in the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page. Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by August 14, 2006. Keep a copy for your records. For your information, the Statement of Deficiencies will be disclosable to the public under the disclosure of survey information provisions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134010	A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	06/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE HOSPITAL SOUTH	700 EAST ALICE (BOX 400) BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a singie story, type II(111) fire resistive building. The facility is fully sprinklered with quick response heads. Also smoke detection coverage is throughout the facility , including sleeping rooms. Currently the facility is licensed for 120 beds. The following deficiencies were cited during a validation survey. The facility was surveyed under the Life Safety Code 2000, Edition, Existing Health Care Occupancy, adopted 3/11/2003, in accordance with CFR 42-482.41. The survey was conducted by: Debra Ransom, RN, RHIT Team Leader Keith Barkow, Health Facility Surveyor Chris Laumann, Health Facility Surveyor	K 000		

RECEIVED
AUG 14 2006
BUREAU OF FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Debra Ransom | Administrator | Aug 11, 2006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134010	A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	06/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE HOSPITAL SOUTH	700 EAST ALICE (BOX 400) BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure there was no impediment to the closing of 1 of two fire doors within the smoke area. The findings include: Observation during the facility tour, on 6/27/06 at 9:40 AM revealed, a rubber door stop propping open the automatic fire door in wing C, unit D. The facility's Physical Plant Director was in attendance and immediately removed the rubber door stop. Corrected on site.	K 018	Corrective Action Plan: Per deficiency summary statement, the cited door stop was removed when it was noted during the survey. The annual training provided to staff covers their responsibilities in maintaining the compartmentalization features of the facility including preventing the unauthorized and unsanctioned practice of blocking open automatic fire/smoke compartment doors. Additionally, the Physical Plant Director, the Safety/Security Director, and their staffs will be directed to increase surveillance to stop this practice. Responsible Persons: The Safety/Security Director will be responsible for monitoring compliance. This will primarily be accomplished by having Security Officers increase their surveillance of room, corridor, cross-corridor, etc. doors in the facility during their routine daily inspections and reporting doors found blocked open with door stops. The Safety/Security Director will ensure noted deficiencies are reported to the Safety Committee, the responsible Department Head; and if a trend is noted, to the Administrative Director. Corrective Date: The cited door stop was removed during the inspection on June 26, 2006.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134010	A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	06/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE HOSPITAL SOUTH	700 EAST ALICE (BOX 400) BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to maintain the ceilings of building in a state to resisit the passage of smoke. This would effect the entire core of the facility as 1 of 5 fire areas. Findings include: Observation during facility tour on 6/17/2006 at 9:50 a.m., revealed a loose escutcheon plate protruding through the false ceiling outside of D wing which left a penetration in the smoke barrier.	K 025	Corrective Action Plan: The loose escutcheon was repaired on June 26, 2006. The Hospital conducts weekly, monthly, quarterly, and annual preventive maintenance inspections of the fire suppression system. In accordance with the applicable code, NFPA 25, the Hospital utilizes a licensed contractor for the annual inspections. During an annual inspection, all sprinklers, including escutcheons, are inspected. Additionally, the Physical Plant Director directs and coordinates bimonthly environmental inspections of the facility. He will be directed to ensure staff participating in the inspections increases their surveillance of the fire sprinkler heads. The Maintenance Supervisor will be directed to instruct Maintenance personnel on proper work methods and means to ensure the ceiling system rating is maintained and to monitor their adherence to the instructions. Responsible Person: The Physical Plant Director will be responsible for ensuring fire sprinklers/escutcheons are routinely inspected and deficiencies are properly reported and corrected. Repeated deficiencies, or an increase in deficiencies noted, will result in increased competency training for Maintenance personnel; and should the problem persists, counseling and/or appropriate disciplinary action. Corrective Date: The cited escutcheon was corrected on June 26, 2006.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134010	A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	06/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE HOSPITAL SOUTH	700 EAST ALICE (BOX 400) BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to ensure proper illumination of exit sign lighting for 2 of 4 exit signs in the entrances to C and D wings. Findings include: Observation during the tour of the facility on 6/26/06, at 9:50 AM, it was discovered the exit sign lighting bulbs were nonoperational in two locations of the C and D Wings entrances, located within the main core of the facility. The facility's Physical Plant Director was in attendance and confirmed the bulbs were nonoperational. NFPA Standard: NFPA 101, Section 7.10.5.2 requires continuous illumination of emergency exit signage, both externally and internally.	K 047	Corrective Action Plan: The lamps were replaced in the two cited emergency exit sign fixtures on June 26, 2006. As a follow-up to the preliminary deficiency report from the survey exit conference, all of the emergency exit sign fixtures in the facility were inspected on June 29, 2006, and June 30, 2006; and the scheduled monthly preventive maintenance inspection of the emergency exit lighting was completed on July 12, 2006, and July 13, 2006. No problems with lamp burnout in emergency exit sign fixtures were noted. Since the survey, the Hospital has begin using a more durable, longer service, higher output lamp in the emergency exit sign fixtures; and has implemented, as a standard of practice reflected in revised preventive maintenance task instructions, the replacement of both lamps in a fixture whenever a fixture has even one (1) burned out lamp. Responsible Person: The Maintenance Supervisor will be responsible for ensuring emergency exit light fixtures are inspected monthly; and deficiencies, including burnt-out lamps, are properly reported and corrected. Corrective Date: The two (2) emergency exit light fixtures cited were re-lamped on June 26, 2006.	